Integrated Care Webinar series 2020/21

The opportunities for systems to improve patient outcomes using digital and data

5 March 2021

NHS England & Improvement System Transformation, in partnership with the Social Care Institute for Excellence (SCIE)

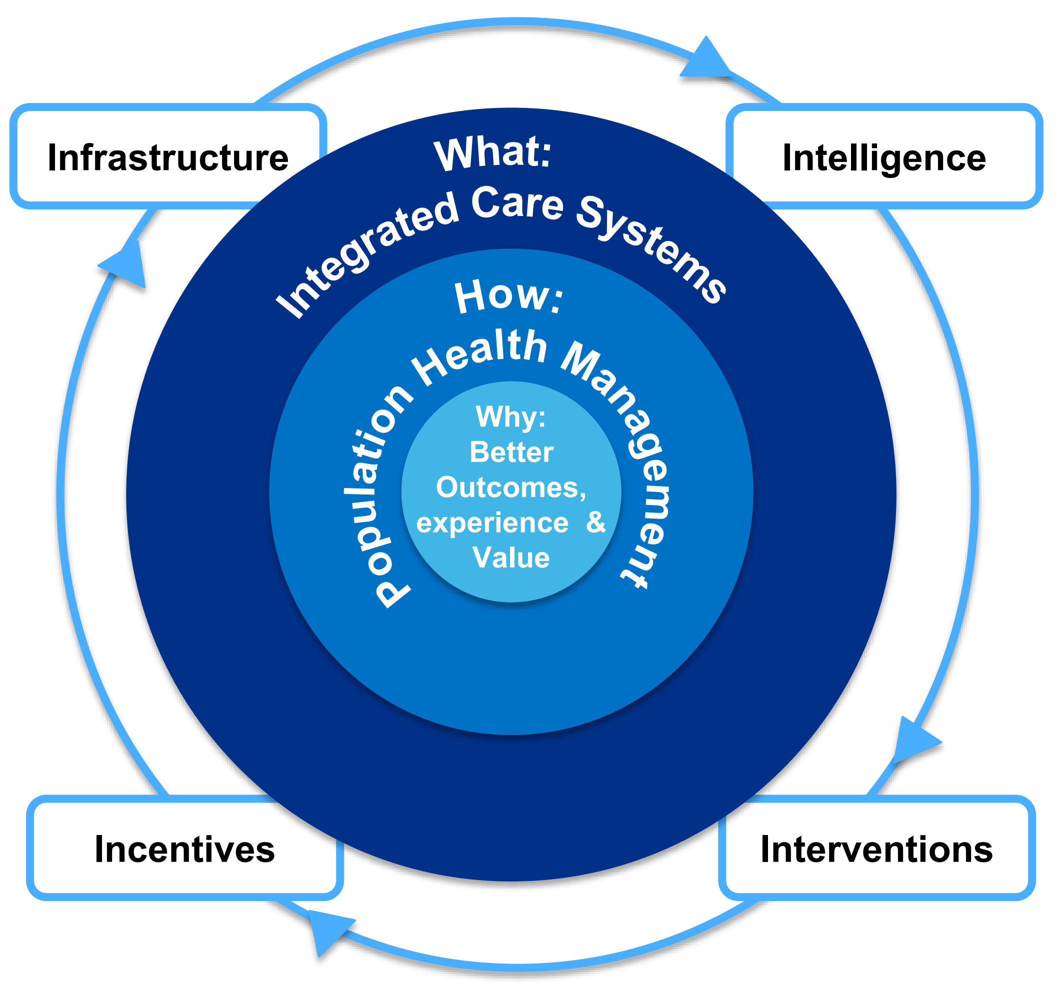
Your speakers today

- Dr Shera Chok - GP, Tower Hamlets, Co-founder and Chair, The Shuri Network, Deputy Chief Medical Officer, NHS Digital and National Clinical Advisor, System Transformation, NHS England and Improvement [CHAIR]
- Dr Karen Kirkham MBBS DRCOG - National Clinical Advisor System Development and Population Health Management NHS England and Improvement, ICS Clinical Lead Dorset, Assistant Clinical Chair Dorset CCG
- Dr John Robson, Reader QMUL, Clinical Lead for the Clinical Effectiveness Group; North East London ICS
- Stephen Slough, Chief Information Officer – Dorset CCG, Chief Information Officer Dorset HealthCare, Chief Information Officer Dorset County Hospital, Portfolio for Director Digitally Transformed Dorset
- Heather Case – Head of DiiS, Dorset CCG
- Dr Simone Yule BSc MB Bch DRCOG - Clinical Director The VALE Network, Clinical Lead Dorset PHM, National Clinical Advisor PHM

Population based transformation and improvement
Prepared for Integrated care webinar March 2021

Dr Karen Kirkham NHSE/I

Population health management



Integrated Care Systems have four main objectives:

1. improving population health and healthcare
2. tackling unequal outcomes and access
3. enhancing productivity and value for money and
4. helping the NHS to support broader social and economic development.

Transforming services and pathways across care settings will require an improvement approach rooted in population and person centred need and addressing inequity – an approach which traverses organisational boundaries and clinical pathways.

Research indicates that integration efforts are not yielding improvements in patient outcomes that we want to see because the attitudes towards new care models from commissioners are driven by short-termism, despite the evidence that time and flexibility is needed to see improvements. (1, 2)

As part of implementing and transforming Integrated Care Systems we need to ensure there is a **clear and evidential connection** from the practical changes that are required; provider collaboration, the financial framework, commissioning, governance and accountability – to enabling a more coherent, smarter and integrated approach **to meeting the current and future needs of local communities.**

Over the last 3 years, ICSs have found that **population health management approaches** - which focus on using data and predicted analytics to join up services and deliver proactive personalised care for complex at risk groups - puts the citizen at the heart of the debate and builds consensus on maximising use of local resources and assets to have the biggest impact on health outcomes.

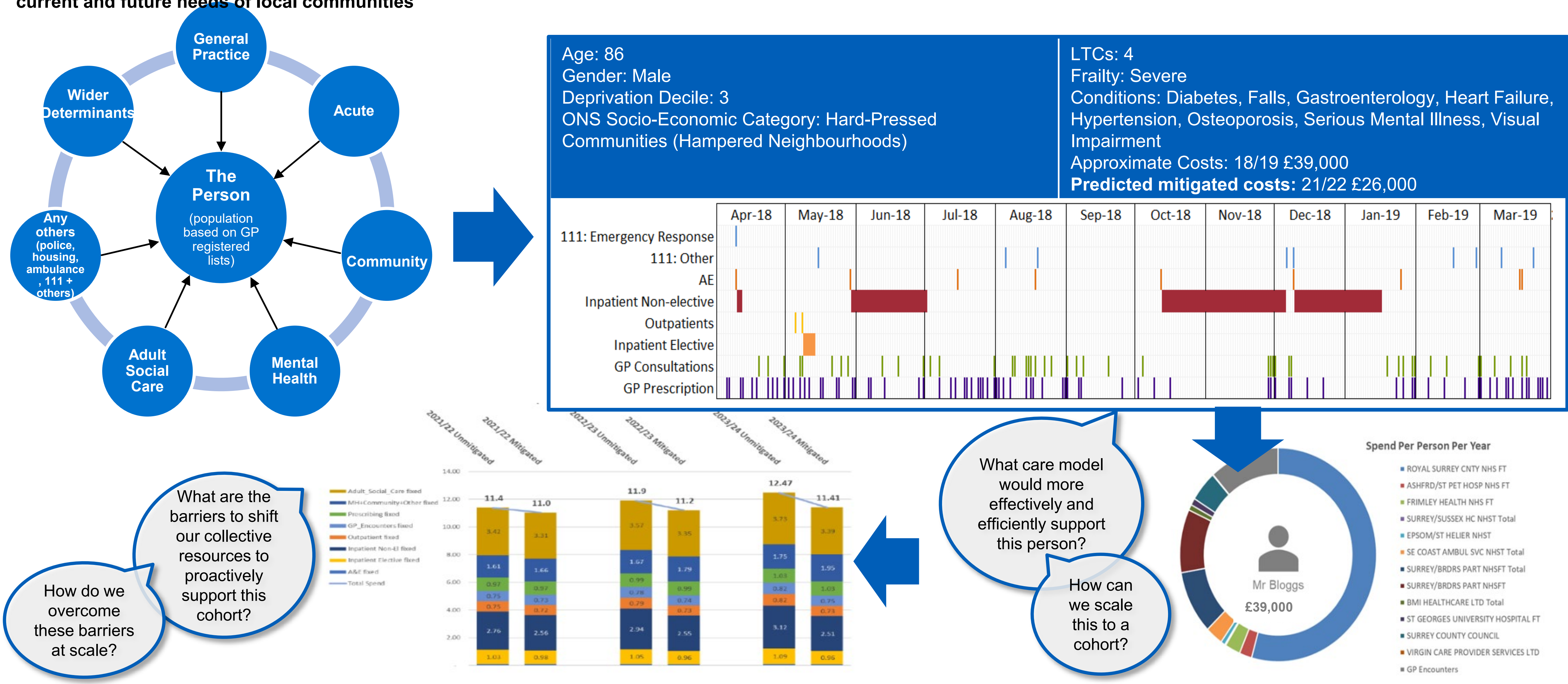
1. https://www.nuffieldtrust.org.uk/resource/evaluating-integrated-care-why-are-evaluations-not-producing-the-results-we-expect
2. https://www.health.org.uk/publications/reports/the-long-term-impacts-of-new-care-models-on-hospital-use-midnotts

Central to this bottom up transformation is joined up data across an ICS

PHM uses integrated data and analytics as the foundation for understanding how to transform the health and care system to prevent future risk.

- Risk drivers to ill-health and hospitalisation (the intersectionality of physical, behavioural, psychological, socio-economic risks)
- And Demand and financial risk placed on different parts of the service currently and projections for the future

This enables local transformation – of pathways, workforce models and working practice, payment and contracting mechanisms, governance and form – to be **evidentially reflective of the current and future needs of local communities**



We believe this can be driven through a data driven whole system learning approach anchored in current and future population need

Understanding current and future health and care needs and risks

- Whole population segmentation and stratification to understand the risks to physical, mental and socio-economic well-being, drivers of ill-health, hospitalisation, unwarranted outcomes and inequalities
- Analyse whole population health and care utilisation by providers and population segments
- Define short medium long term outcomes aligned to population segments

Predictive risk and financial modelling for key population groups

- Projecting these segments forward to understand how cost and risk will change over time for these groups.
- Estimates can then be made for where the biggest improvements in care and prevention can be made.
- Agreeing priority population cohorts where tactical service redesign will improve short and long term outcomes and mitigate future demand and financial risk

Care model design & delivery at place through PCNs and partners

- Multi-disciplinary design across primary, community, secondary care partners, VCSE, social care and public supported by system analytical and clinical transformation teams
- Adopting logic model approach to understanding partner inputs (e.g. workforce), activities, outcomes focusing on proactive assessment and ongoing care-coordination
- Citizen and community engagement through holistic care design and preventative care

Resource model (workforce, payment and incentives)

- Developing sustainable blended payment for population segment which outlines fixed, outcomes-based and risk share elements across responsible providers
- Outline integrated workforce model for population segment across responsible providers which includes healthcare professionals, social care, VCSE and carers involved in person centred care

Oversight and evaluation of care model

- Developing a clear approach to measuring and tracking outcomes for population segment ensuring this forms part of overall system oversight and governance model and outcomes framework
- Clear plan to learn and adapt from implementation using QI methodology

Embed service redesign through system commissioning, governance and functions

- Adapting governance at system and place to enable shared learning, spread and sustainability
- Developing a sustainable approach to alliance contracting for population segments
- Review of system support and enabling functions to sustain focus on continuous improvement across population segments

System
Place
Neighbourhood
Person

Key planks of work

Policy

- Co-design, testing and delivery of
- System integration metrics; 21/22 SOF, refresh through system testing, 22/23 SOF
- National integration index – a new patient experience measure of integrated, anticipatory and personalised care – pilot, options appraisal and procurement/mobilisation
- ICS Support Services market strategy

Data, analytics and digital

Primary Care, NHS@Home, Health Inequalities and Personalised Care

Place partnerships and provider development

Commissioning and system/place functions transformation

Financial framework, aligned payments and incentives

Oversight, metrics and outcomes

People and workforce development

Improvement support, clinical priorities, model system

Support

- Wave two – 12 systems, 14, places, 50 PCNs
- Wave three – 24 systems, 24 places, 100 PCNs
- Place partnerships PHM support
- PHM programme evaluation
- Regional capability support to Improvement Hubs
- Health System Support Framework

Spread

- **Academy** **partners**
- **Engagement**
- **CSU and AHSNs**

Data should drive decisions across all parts of a system

Decisions ← *Data*

System

Decisions

- **Planning and strategy** – understanding the burden of inequality and need, how this drives service utilisation and overall wellbeing and how demographic and demand pressures are likely to shape provision and risk between organisations
- **Commissioning** based on outcomes for population segments and future need and demand profile
- **Research and evaluation** – undertaking longitudinal studies to identify preventative interventions and understanding the impact of new care models on experience, outcomes and utilisation.

Data

- Overview of **clinical and socio-demographic risk factors** distribution, with comparisons across provider catchments and geographic footprints
  Projections of key drivers of demand and utilisation, including health inequalities
- **Data showing the current utilisation and cost of pathways** and care settings by population group and modelling to indicate likely impact of new interventions and care models
- **Financial modelling** to create service, pathway and population based blended payment models
- De-identified person level historic data (synthetic dataset) to run **research trials**

Example on-plan spend and elements of the payment mechanism across multiple providers

Payment Element	Example
Fixed	70%
Quality/Outcomes-based	20%
Risk-Share	10%

300
250
200
150
100
50
251
254
260
2021/22 Plan Spend
2021/22 Payment
2022/23 Plan Spend
2022/23 Payment
2023/24 Plan Spend
2023/24 Payment
Social_Care+CHC risk
Social_Care+CHC quality
Social_Care+CHC fixed
MH+Community risk
MH+Community quality
MH+Community fixed
GP risk
GP quality
GP fixed
Acute risk
Acute quality
Acute fixed
plan

Place

Decisions

- **Operational management** of patient flow and service activity supporting demand management and capacity planning short, medium and long term (command centre)
- **Population health and health inequalities** – understanding drivers of disproportionate and unwarranted health outcomes and the new and emerging needs of different population groups
- **Tactical commissioning and contracting** for service specifications and care models within a provider collaborative supported by place based budget management and the move to innovative capitated payment models
- **Quality management & improvement**

Data

- **Planned and unplanned care service data** indicators
- **Real-time capacity tracking** to model and match staff rostering and appointments to patient transfers in and out of hospital
- **Population segmentation** for different definitions of place or catchment footprint and **wider determinant data** and information on local inequalities
- **Service utilisation and costs** by provider organisation and population segment
- Modelling of preventative interventions and proactive care models and accompanying payment mechanisms
- **Service pathway metrics benchmarked** against comparable/local organisations and national averages & Service outcomes data linked to population demographics

Clinical Risk Factors (COVID-19 and/or Long Term Conditions)

Psycho-social Risk Factors (Mental Health and Social Need)

	Low Clinical Risk	Single LTC or COVID Risk	Multiple LTCs or COVID Risks	Very High Risk for COVID
Low Psycho-social Risk	184,461 51% £216 PPPY	37,752 11% £528 PPPY	28,590 9% £1,076 PPPY	9,311 2.5% £3,290 PPPY
Mental Health Need	141 <1% £787 PPPY	20,464 6% £477 PPPY	14,544 4% £1,395 PPPY	2,718 <1% £4,462 PPPY
Social Risk Factors	50,066 14% £242	7,939 2% £598 PPPY	4,708 1% £1,184 PPPY	1,715 <1% £2,976
Both Mental Health + Social Risk	61 <1% £952 PPPY	5,242 1% £527 PPPY	3,667 1% £1,418 PPPY	651 <1% £4,441 PPPY
Total (Pop. 372,030)	234,729 63% £222 PPPY	71,397 19% £521 PPPY	51,509 14% £1,200 PPPY	14,395 4% £3,526 PPPY

PCN

Decisions

- **Clinical and MDT care** supported by risk stratification and population health analysis to identify gaps in care and unwarranted variation
- **Benchmarking across network** and within place to identify future service changes and development support

Data

- Local population **segmentation and stratification** by socio-demographics, clinical or healthcare needs and service utilisation/costs
- **Cross-PCN data on service utilisation, costs and outcomes data**
  QOF data and comparison of metrics across PCN service specifications

Reasons for Inclusion in High Risk (Local)			
Age 70+	0	9,816	8,532
Asthma (Non-Severe)	0	10,839	3,301
Atrial Fibrillation/Flutter	0	416	2,128
Chronic Renal Issues	0	82	1,048
COPD (Non-Severe)	0	290	964
Diabetes	0	2,071	4,325
Disseminated Tuberculosis	0	16	17
Heart Conditions	0	811	3,961
Obesity (Coded or BMI 40+)	0	2,267	2,672
Occ/Enviro Pulm Diseases	0	65	141
Recent Pregnancy	0	1,238	322
Splenectomy	0	35	33

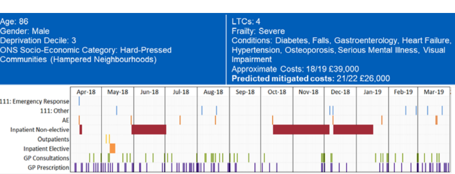
Person.

Decisions

Promotion of **self care and personal wellbeing**

Data

- Read and write access to the shared care record to record self monitoring information (through devices) and to push self care personalised messaging and coaching
- Financial information to support personal health budgets



Where to start – population health management capability

Infrastructure

- **Organisational and human factors** such as dedicated system leadership and decision making on population health and PHM
- **Digitised health & care providers** and **common integrated health and care record**
- **Linked health and care data architecture** and a single version of the truth
- **Information Governance-** whole system data sharing and processing arrangements that ensure data is shared safely, securely and legally

Intelligence

- **Whole System Population Health Intelligence Function** with multi-disciplinary analytical and finance teams equipped with advanced **analytical tools** and software
- **Timely analyses and actionable insight** to understand health and wellbeing needs of the population, opportunities to improve care, manage risk and reduce health inequalities
- **Agile and responsive ways of working across multi-disciplinary groups** comprising clinical, improvement, analytical teams working hand in hand with providers

Interventions

- **Care model design** and delivery through` proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities
- **Community well-being** - asset based approach, social prescribing and social value projects
- **Citizen co-production** in designing and implementing new proactive integrated care models

Incentives

- **Incentives alignment** – value and population health based contracting and blended payment models
- **Workforce development and modelling** - upskilling teams, realigning and creating new roles
- **Enabling governance** to empower more agile decision making within integrated teams

Equitable health improvement in east London

A digital journey

- High performing CCGs despite exceptional challenges
- A decade ahead of similar disadvantaged areas

DIGITALLY INTEGRATED

- smart templates
- prompts/protocols
- searches
- smart forms
- dashboards
- responsive BI

NHS

PHISIC

Population Health Information System for Integrated Care

Learning Health System

is built on…..

- Trust
- Reciprocity
- Clinical focus
- BI and research

Digital infrastructure essential component

East London Practices – Exceptional success

C&H and TH 1st, 2nd in 25% QOF metrics;
Newham, Barking and Dagenham, Redbridge improvement++

C&H 2013

21st COPD FEV1
41st AF anticoagulated
148th Diabetes BP
181st Diabetes chol

C&H 2014

1st AF anticoagulated *
1st Diabetes foot exam
2nd CHD BP
2nd Stroke BP
*** with exceptions**

C&H 2015

1st BP target CHD, Stroke, PAD, CKD
1st AF anticoagulated (with exceptions)
1st COPD x spiro, MRC, FEV1
1st Asthma review
1st Diabetes exam
2nd Diabetes education
2nd Dementia review
3rd Hyptn BP
3rd Diabetes BP

C&H 2016

1st AF Anticoagulated (with exceptions)
1st CHD BP
1st HYPTN BP
1st PVD BP
1st Stroke BP
1st Asthma 3Q
1st COPD Spirom
1st COPD MRC
1st COPD FEV1
1st Diab BP
1st Diab exam
1st Smoking advice
2nd Diab Chol
2nd Dementia

CHD BP <150/90mmHg QOF 2005-18

ceg
Clinical Effectiveness Group

100 %
95
90
85
80
75

% BP <150/90

Tower Hamlets
C&Hackney
Barking&Dag
Redbridge, Havering
Newham
England

2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2018

Diabetes BP< 140/80mmHg Index of Material Deprivation and QOF 2019

MOTIVATE – Dashboards near real time

INTEGRATED CARE 2017-2018: PRACTICE TREND — 12 MONTHS

1.4.18 << Select Month | ICS Reduction from 01/04/2017 | Select Indicator | Aberfeldy Practice | << Select Network | F84698

IC24-RSPaa IC24-RSPaa-D

COPD (EXCL ASTHMA): ICS REDUCTION FROM 01/04/2017 — 12M/FY << Switch to FY

MONTH ACHIEVEMENT TREND

PROGRESS TO TARGET

Remaining, -35%

< Target

> Target

Completed

TARGET EXCEEDED BY 2

-2

COMPLETED	GOAL REACHED
43%	✓

RANKED ACHIEVEMENT + CHANGE FROM 01/04/2017

TARGET

20%

ELIGIBLE	7
COMPLETED	3
TARGET	1

ceg Clinical Effectiveness Group

End of Life 2017-2018

20/04/2018 << Select Q4 FINAL

Select>> London Fields Medical Centre F84021

EOL01a	Completed Palliative Care Templates	21
MIN	Minimum Target	21
MAX	Maximum Target	41
01-APCR	Anticipatory Palliative Care Register	17
EOL01a1	Advance Care Plan (ACP) drafted	9
EOL01a2	ACP declined	9
EOL01a3	Coordinate My Care (CMC) consented	12
EOL01a4	CMC declined	0
EOL01a5	Resuscitation/CPR (DNAR) discussion*	12
	No DNAR discussion	9
EOL01a7	Preferred place of death achieved	2
	Preferred place of death not achieved	19

APL-AF Atrial Fibrillation Tool

Select Clinical System ○ EMIS ○ SystmOne ● Vision ○ Microtest | Anonymised DATA

Press to locate CSV file(s) | Press START when Data is Cleared | START | RESET to clear | Date of last run: 16/Nov/2017

Filters

Prescribing: ● All AF ○ Warfarin/NOAC only ○ Aspirin/Clop only ○ On Both ○ On Neither

CHADSVASc (APL): ☐ ≥ 2 ☐ 1 ☐ 0 ☐ GP No Record | Age: ☐ < 65 ☐ 65 - 74 ☐ 75+

Complex risks: ☐ SMI ☐ Learning Disability ☐ Dementia | On NSAID ☐

Anticoagulation Contraindicated ☐

Reset Filters

Summary

Atrial Fibrillation Register	38
On Warfarin/NOAC only (6m)	35
On Aspirin/Antiplatelets only (6m)	0
No treatment	1
Both Anticoag + Antiplatelets (6m)	2
CHADSVASC ≥ 2 on anticoagulants	33
CHADSVASC ≥ 2 on antiplatelets only	0
CHADSVASC ≥ 2 with no treatment	1

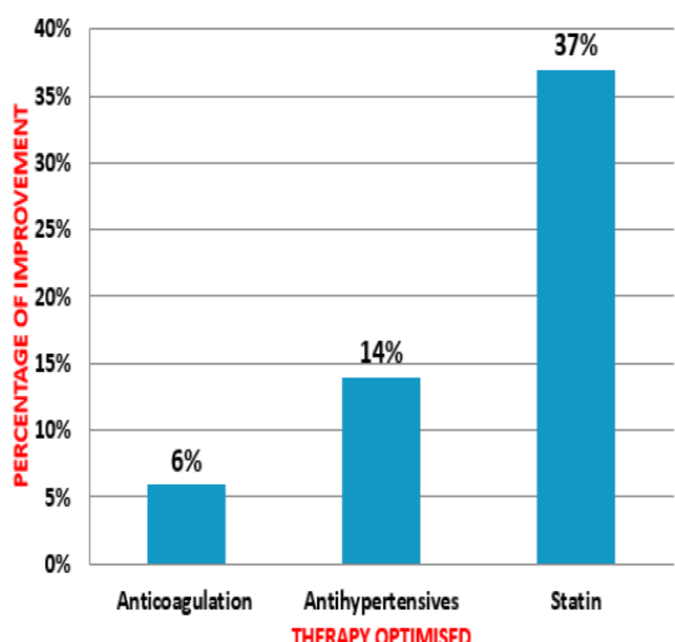
Prescribing

92% | 5% | 0% | 3%

On Warfarin/NOAC | On Aspirin/Clopidogerel | No treatment | Both

Full Name	Patient Reference no.	Usual GP	Age	Sex	CHADSVASc (APL)	CHADSVASc (GP)	CHADSVASc (GP) date	HAS-BLED Score (APL)	On Aspirin/ Antiplatelets	On warfarin/ NOAC	On NSAID	On Statin	Medcation Review (Pharmacist or detailed GP review)
cb1dc3584 -0e44-02fffc6d8584	PN: 00584	G8513728	93	Female	6			1	NO	CONTRA - E	NO	YES	
cb1dc3438 -0e44-02fffc6d8438	PN: 00438	G8513728	83	Male	6	5	20-Oct-2016	2	NO	YES - NOAC	NO	YES	
cb1dc3938 -0e44-02fffc6d8938	PN: 00938	G8513728	82	Female	6			2	NO	YES - 3rd P(?OA	NO	NO	
cb1dc3111 -0e44-02fffc6d8111	PN: 00111	G8513728	76	Male	6			2	NO	YES - 3rd P(?OA	NO	YES	
cb1dc3597 -0e44-02fffc6d8597	PN: 00597	G8513728	91	Male	5			2	NO	YES - NOAC	NO	YES	
cb1dc3776 -0e44-02fffc6d8776	PN: 00776	G8513728	84	Female	5	5	#########	2	NO	YES - NOAC	NO	YES	
cb1dc3626 -0e44-02fffc6d8626	PN: 00626	G8513728	78	Female	5	3	#########	2	NO	YES - NOAC	NO	YES	

Redbridge improvement 2017/18 – 2018/19

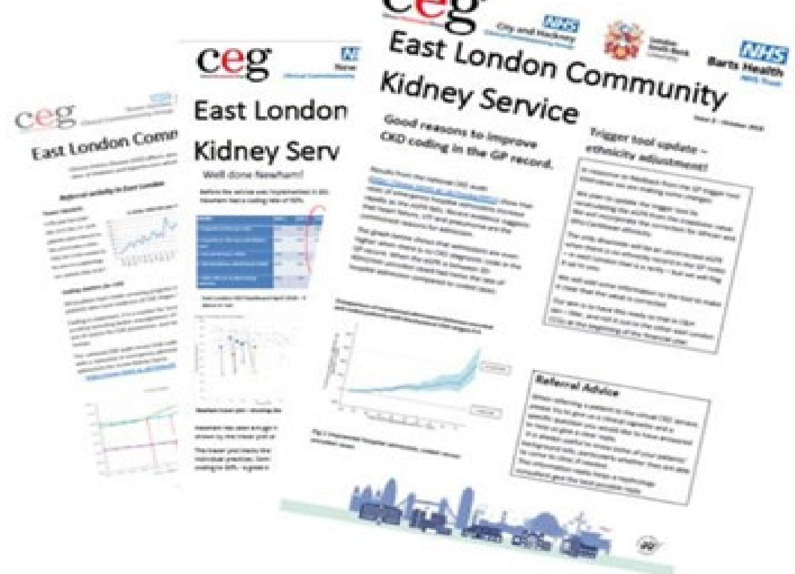


Research

New service models: Virtual renal clinics

Promotion of rapid testing for HIV in primary care (RHIVA2): a cluster-randomised controlled trial

Werner Leber*, Heather McMullen*, Jane Anderson, Nadine Marlin, Andreia C Santos, Stephen Bremner, Kambiz Boomla, Sally Kerry, Danna Millett, Sifiso Mguni, Sarah Creighton, Jose Figueroa, Richard Ashcroft, Graham Hart, Valerie Delpech, Alison Brown, Graeme Rooney, Maria Sampson, Adrian Martineau, Fern Terris-Prestholt, Chris Griffiths



- Now implemented in east London CCGs
- **50%** reduction in nephrology **OPD appts**

Achieving successful improvement

It's a system not a plug-in!

Capable

Evidence

Stakeholders

Consensus

Guidance and KPIs

Education

Actionable

IT support

Templates

Prompts

APL & Trigger tools

Patient recall

and review lists

Motivated

Financial targets

Dashboards

Peer performance

Learning

Actionable

- Web enabled – Integrated systems for IT
- IT decision support, search and analysis
- Locally engineered and responsive
- CCG, **GP provider,** and public health facing
- Academically supported

And also facilitated

Integrated accessible data for
Direct care
Commissioning
and Research

Timely, responsive and integrated: Covid

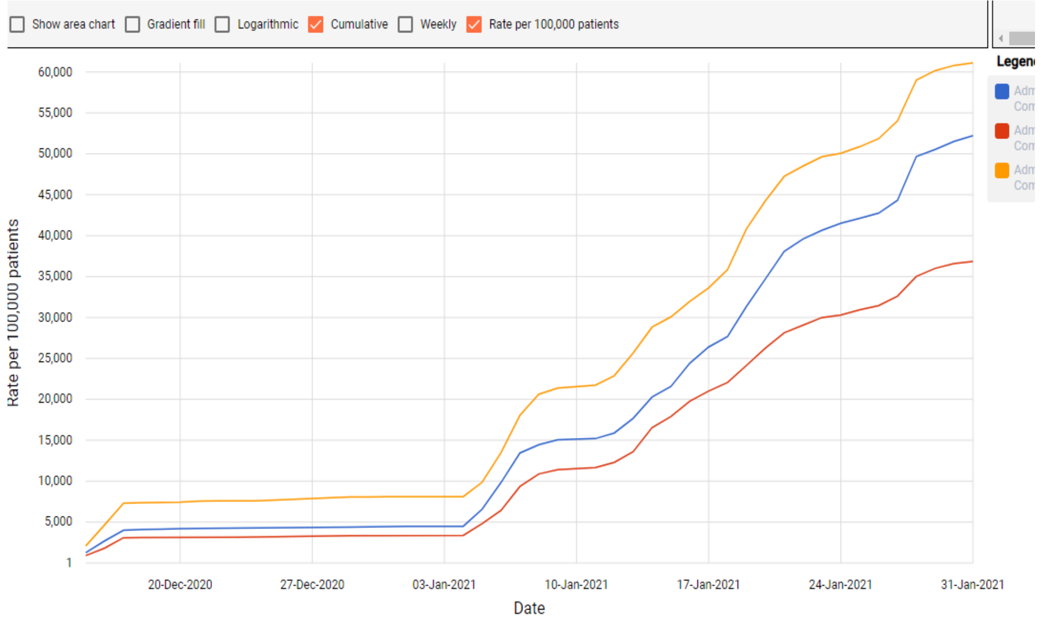
Rate/100,000 confirmed Covid to Jan 2021 LONDON

2021-01-05 : (rate per 1,000 registered patients)

Watford
Rickmansworth
Chipping Barnet
Enfield
Loughton
M25
Brentwood
East Finchley
Hampstead
Camden Town
Wandsworth
Wimbledon
Teddington
Kingston upon Thames
Staines-upon-Thames
Chertsey
Walton-on-Thames
Sutton
Croydon
Dartford
Northfleet
Grays
Tilbury

COVID Vaccination NEWHAM Feb 2021

White S Asian Black



EQUITY 90% Ethnic group self-reported
IMD score 100%
Learning disabled 99%
Care Homes – just added!

Identifiable shielding lists for LA and othe

DATA NHS ICS DISCOVERY

Population Health

PHISIC **Information System**

for Integrated Care

Responsive,
Accessible, timely data

Research

Direct care

BI
Commissioning
Public health

It's a system… (federated)

- **choose wisely** quick wins
- **clinically led** and engaged
- **facilitators** are the spinal cord
- **data** integrated, accessible, timely and responsive
- **patient apps** integrated with GP records

PHISIC

Population Health
Information System
for Integrated Care

Responsive,
Accessible, timely data

Research

Direct care

BI
Commissioning
Public health

Dorset ICS

Introducing the DiiS

4th March 2021

18 Primary Care Networks

79 GP Practices

810,000 Registered Population

NHS Dorset Clinical Commissioning Group

Dorset Police

NHS Dorset HealthCare University NHS Foundation Trust

Dorset & Wiltshire Fire and Rescue

BCP Council

Dorset Intelligence and Insight Service

System Resilience

PCN Intelligence

Developments/Partners

ICS Intelligence

(DiiS) shortlisted for Institute of Collaborative Working Award

NHS Dorset County Hospital NHS Foundation Trust

Public Health Dorset

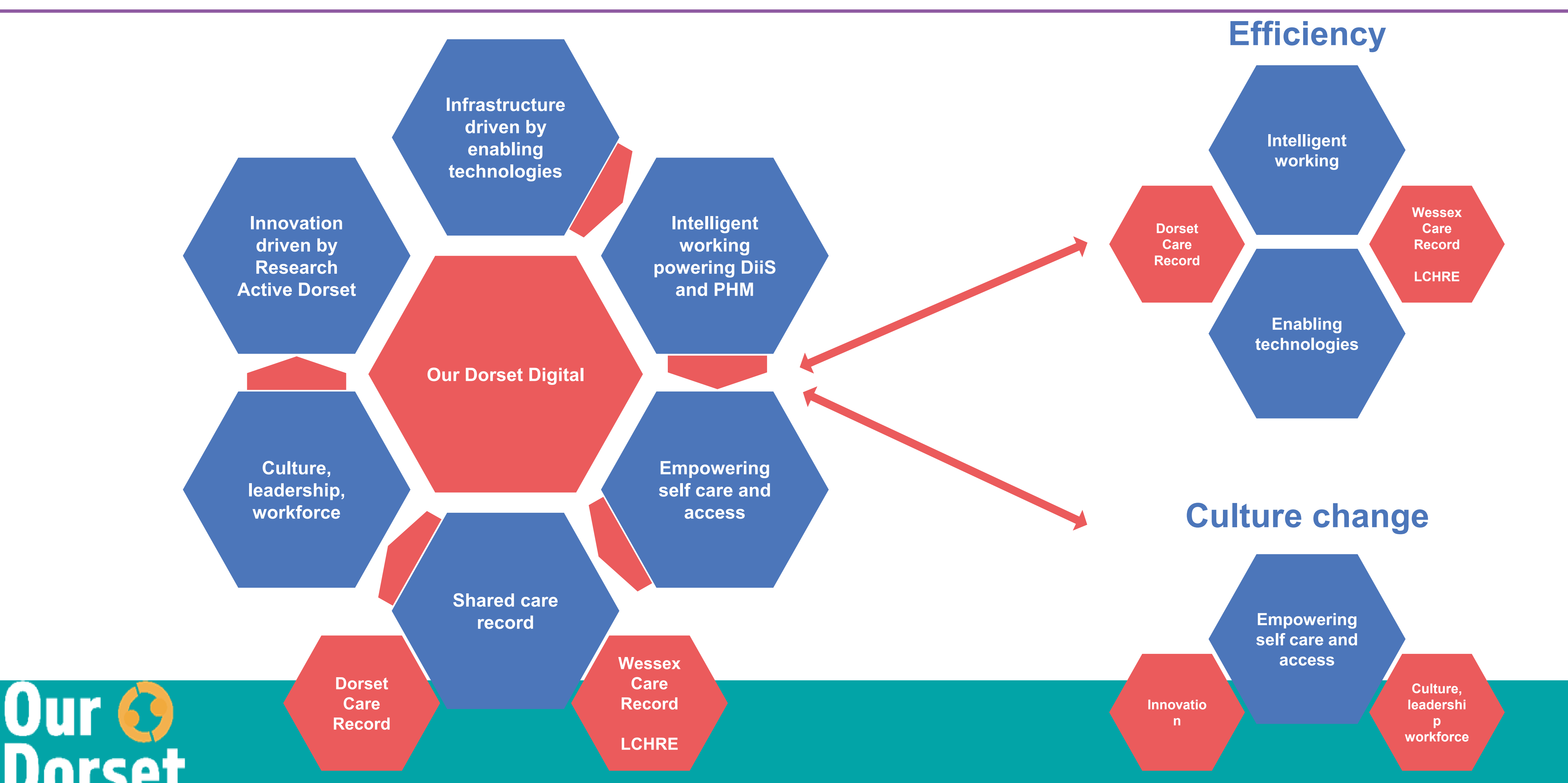
Cornwall and the Isles of Scilly Health and Care Partnership

Dorset Council

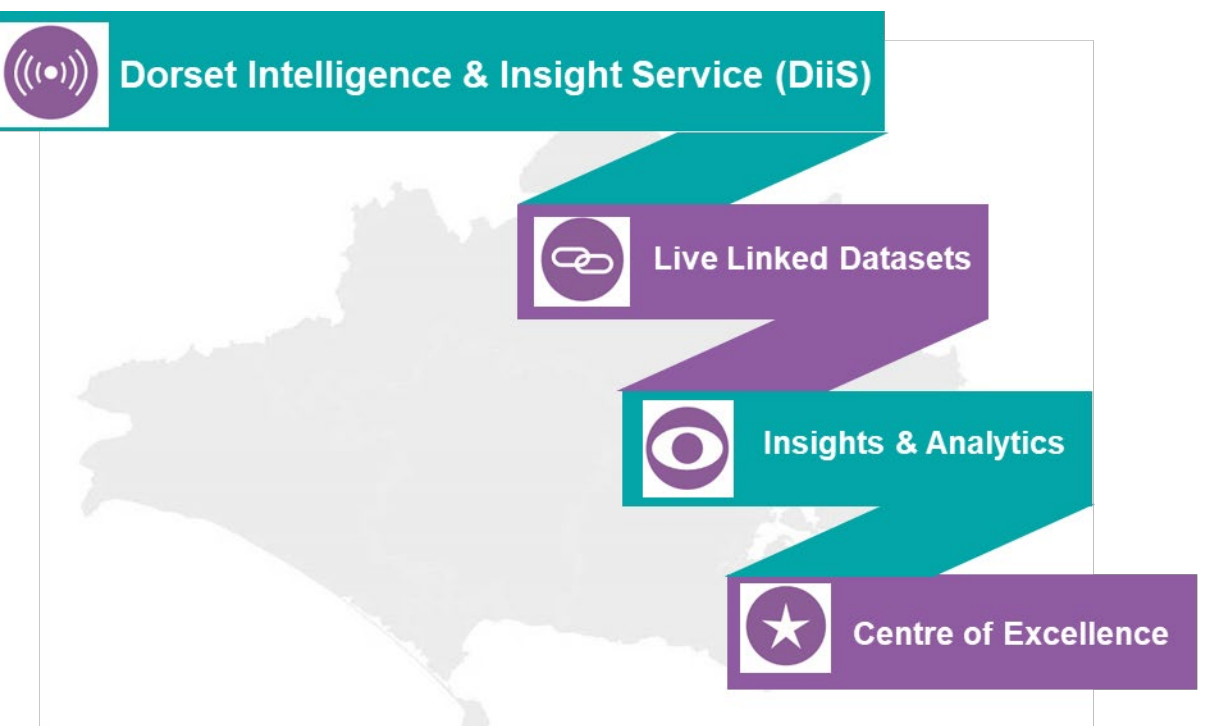
NHS South Western Ambulance Service NHS Foundation Trust

NHS University Hospitals Dorset NHS Foundation Trust

Dorset's Digital Portfolio



ICS - Intelligent Working Programme



Mission Statement:

We have an ambition to significantly transform the way information and data is used across the ***Integrated Care System*** to support the design and planning of health and care services. The Intelligent Working programme will deliver a data warehouse and management information system using data collected from the ***shared care record*** alongside that from GP practices, social care, community, mental health services and hospitals.

We will link these data sets and combine with demographic, housing and education information giving us county wide picture of our ***population health management***.

Dorset Intelligence & Insight Service

System Resilience

Population Intelligence

Our Dorset

INTELLIGENT WORKING

Developments/Partners

ICS Intelligence

Version 2.3
January 2021
dhc.iwp@nhs.net

Our Dorset
Your Local NHS and Councils Working Together

COVID Reporting

Coronavirus COVID-19 Dorset Cases

Click to View:

Overall

Last 14 days

Our Dorset

Check https://coronavirus.data.gov.uk/ for the latest national confirmed cases

Report Last Updated: 04/03/21 20:31:05

Confirmed Deaths

Hospital Deaths

42

Care Homes Deaths

21

Primary Care SITREP:

03/03/21

Primary Care % Absence (all)

2%

Primary Care % COVID-19 Absence vs Absence (all)

26%

Pillar 2 Testing

Pillar 2

For detailed report please click here

Tested Positive

591

Total Tested

18182

Pillar 2 Positive Tests by LSOA Centre points

Bridgwater, Taunton, Seaton, Dorchester, Weymouth, Little Sea, Swanage, Bournemouth

© 2021 Microsoft Corporation Terms

Pillar 2 Positive Tests per Day

Positive tests · Rolling 7 day average

200, 100, 0 — 18 Feb, 25 Feb — Result Date

Positive Tests by Age

Age	Positive tests
91+	7
81-90	16
71-80	23
61-70	46
51-60	96
41-50	116
31-40	120
21-30	99
11-20	41
0-10	27

SystmOne 111 Calls

CALL 111

Definitive COVID-19: 74

COVID-19 mentioned: 1203

COVID-19 Related 111 Calls per Day

141, 51

Data to: 03/03/21

Acute Screening

Total Confirmed Cases (+ve swabs): 114

Inpatients Recovered: 126

Data as at: 04/03/21 20:31:05

Total Tests Completed with Results

RBH	PHT	DCH	YDH	SFT
4674	4071	1900	255	11

Acute Lab Confirmed Cases per Day

+ve swabs · +ve swabs rolling 7 day average

+ve swabs: 10, 0 — 18 Feb, 25 Feb, 04 M — Result Date

Latest SITREP as at: 04/03/21

COVID-19 patients in beds as at 0800	Beds with Mechanical Ventilation available	COVID-19 patients receiving Oxygen/Ventilation	COVID-19 related staff absences	NHS staff COVID-19 hospital admissions
51	6	13	362	2
Previous Day: 61	Previous Day: 6	Previous Day: 15	Previous Day: 354	Previous Day: 2
(-10 -16%)	(+0 +0%)	(-2 -13%)	(+8 +2%)	(+0 +0%)

COVID Vaccination Reporting

Covid Vaccination Status - Dose 1

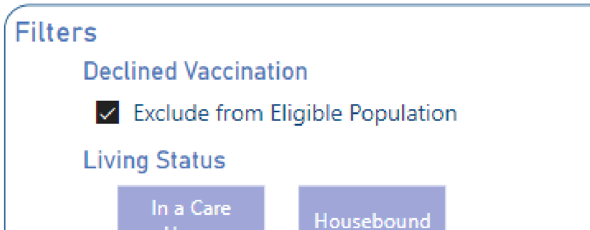
Patients that have received Vaccination Dose 1

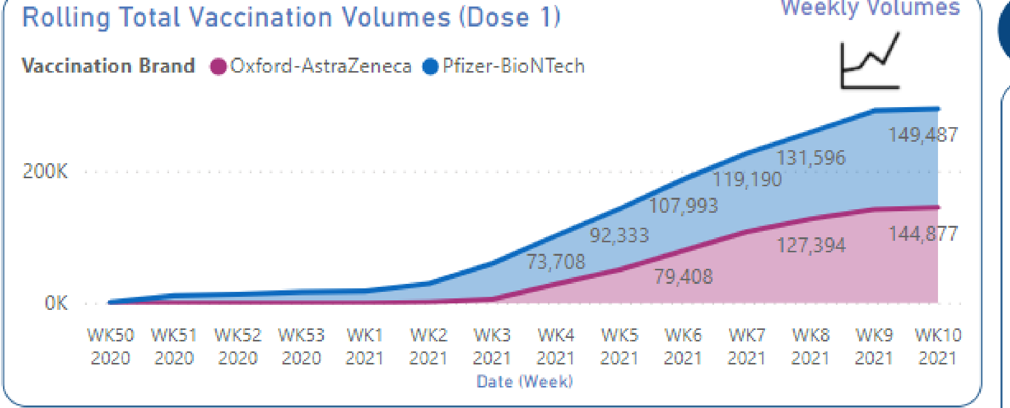
PrimaryCareNetwork: All

Gp Surgery: All

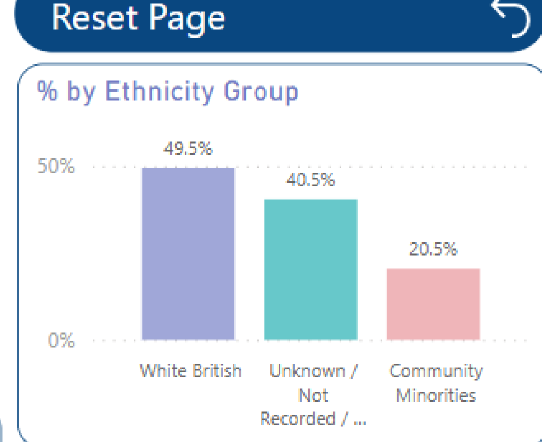
Data updated to: 02 March 2021

Vaccinated	80 + Years	< 80 Years	Vaccination Declined	Lives in a Care Home
294,181	54,609 (96.9%)	238,058 (39.6%)	3,935	5,148 (92.3%)
Vaccination Volumes (Rolling Total)	(Inc Care homes)	(Inc Care homes)	Declined	Vaccination Volume



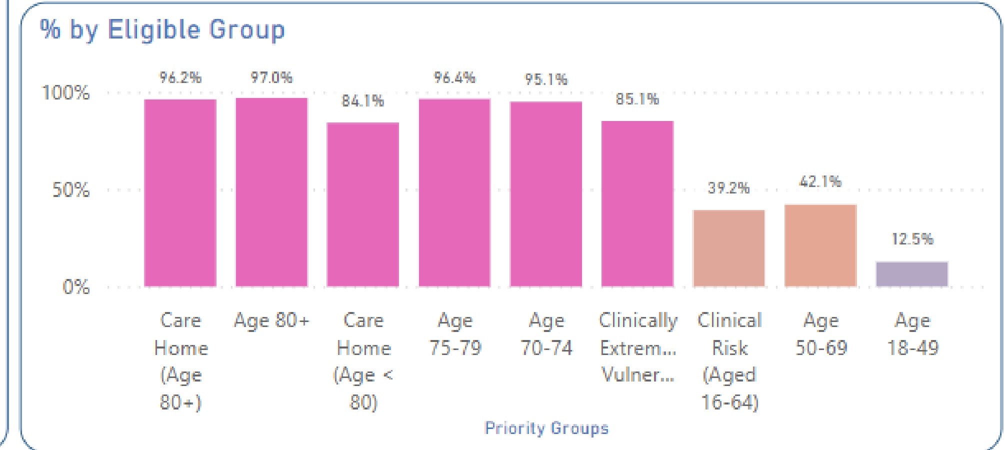


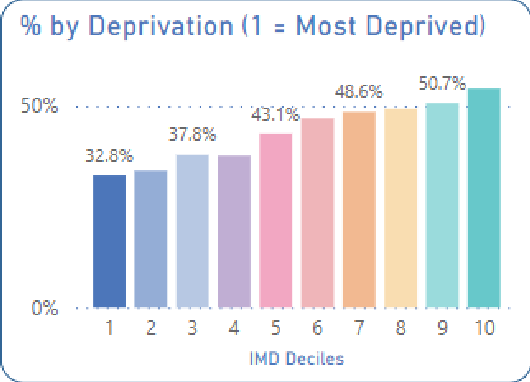
Reset Page



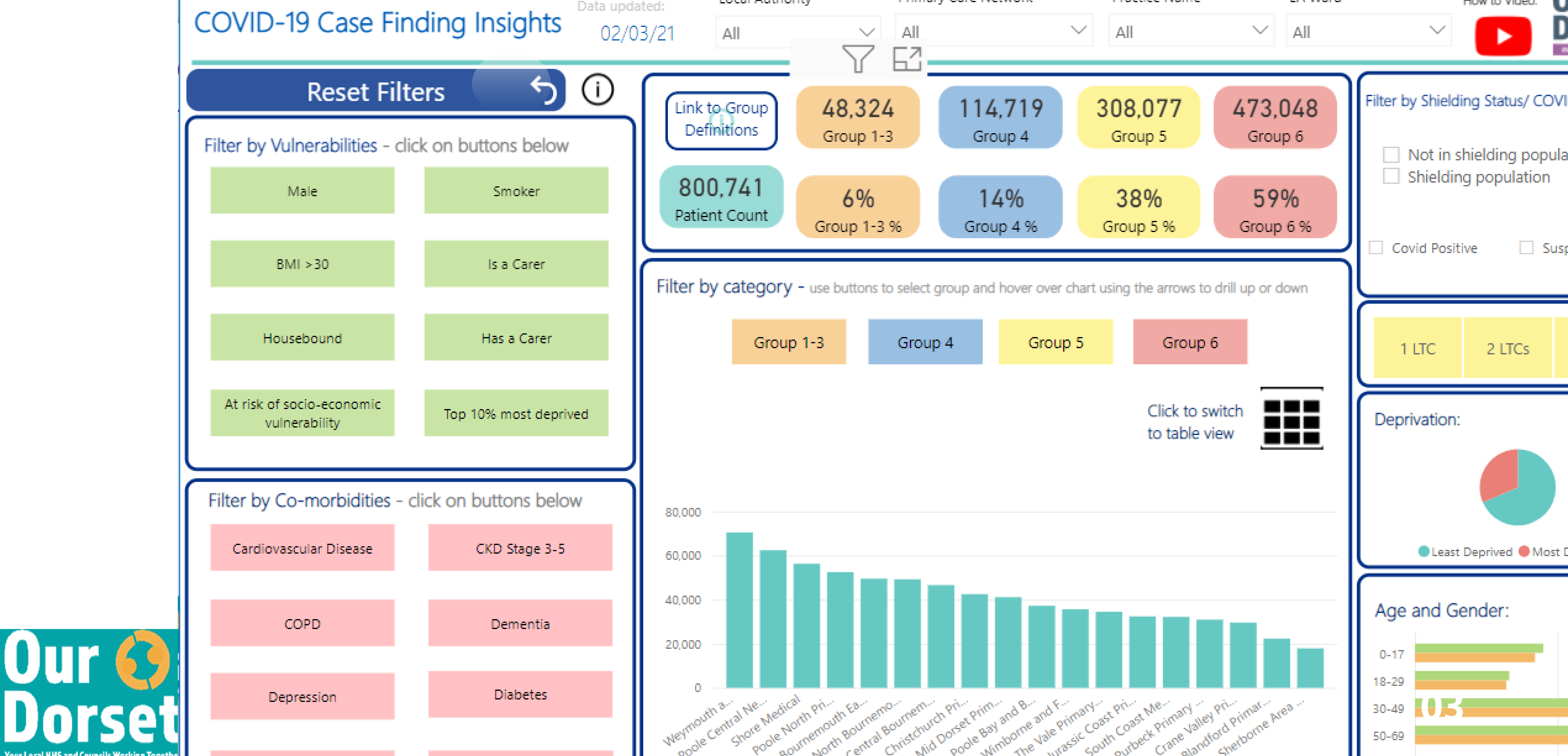
Eligible Groups

Eligibility Group	Eligible	Vaccinated	%
Care Home (Age 80+)	3,779	3,634	96.2%
Age 80+	52,562	50,975	97.0%
Care Home (Age < 80)	1,800	1,514	84.1%
Age 75-79	38,193	36,816	96.4%
Age 70-74	51,188	48,661	95.1%
Clinically Extremely Vulnerable	21,507	18,297	85.1%
Age 65-69	43,369	37,613	86.7%
Clinical Risk (Aged 16-64)	98,847	38,730	39.2%
Age 60-64	33,895	12,212	36.0%
Age 55-59	39,823	8,810	22.1%
Age 50-54	40,353	7,616	18.9%
Total	**659,552**	**294,181**	**44.6%**





COVID Insights



DiiS Inequalities

Profiling Insights

Latest Date:

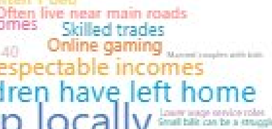
01 March 2021

NOTE: Page filters have been applied, check the filters pane or click here to reset all

Population Count: **76,068**

% Population: **10%**

Key characteristics

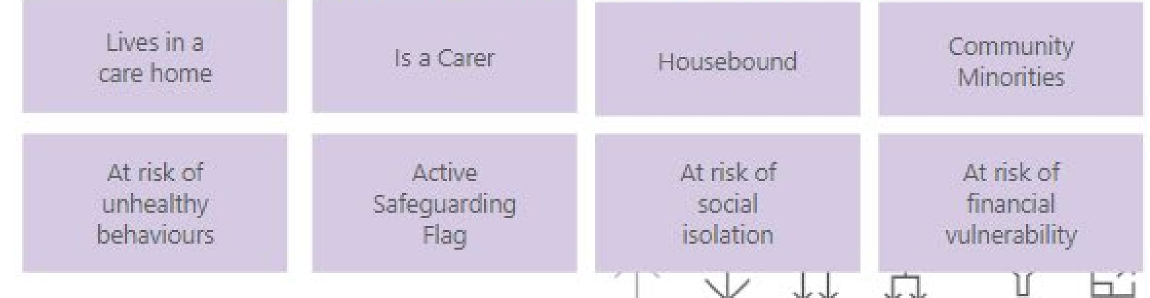


Age Profile

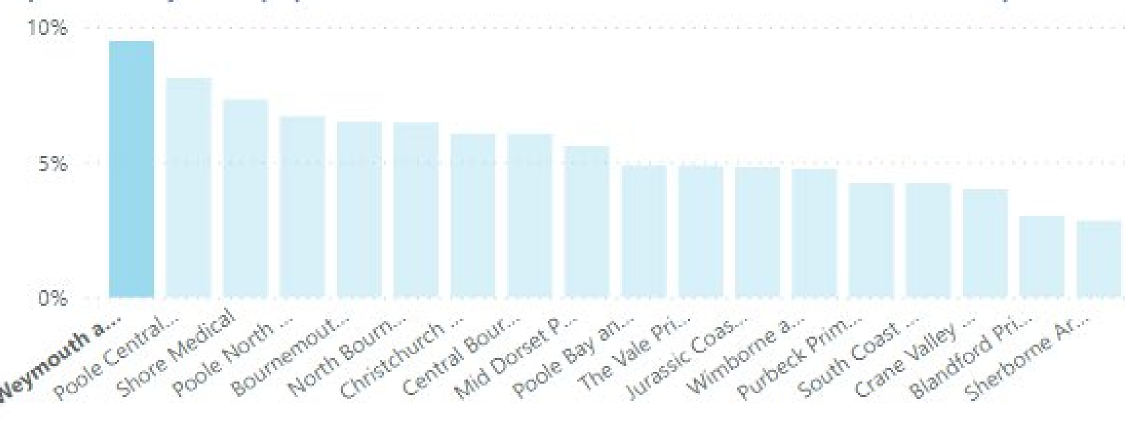
Age	Female	Male
85+	2%	1%
75-84	5%	4%
65-74	7%	7%
55-64	8%	8%
45-54	7%	7%
35-44	5%	5%
25-34	5%	5%
15-24	5%	5%
05-14	5%	5%
0-4	2%	2%

● Female ● Male

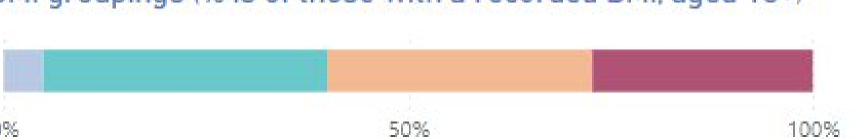
Use buttons to filter report by vulnerabilities



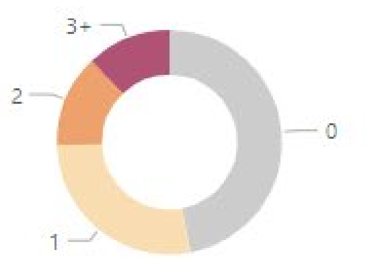
Proportions by total population - hover over chart and use arrows to drill up or down



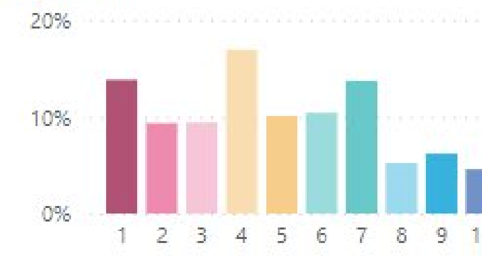
BMI groupings (% is of those with a recorded BMI, aged 18+)



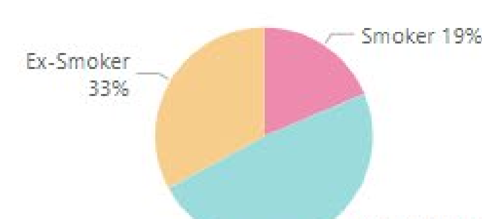
Number of long term conditions in population



Deprivation Deciles (where 1 is mos deprived)



Smoking Status



DiiS Safeguarding

Safeguarding Insights

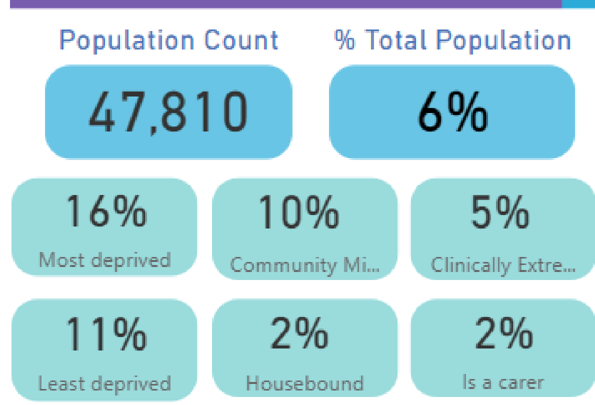
This page focuses on only those with a currently active safeguarding flag

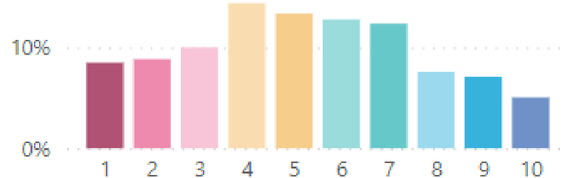
This report is under development

Latest Date:
23 February 2021

Click icon to open filter pane

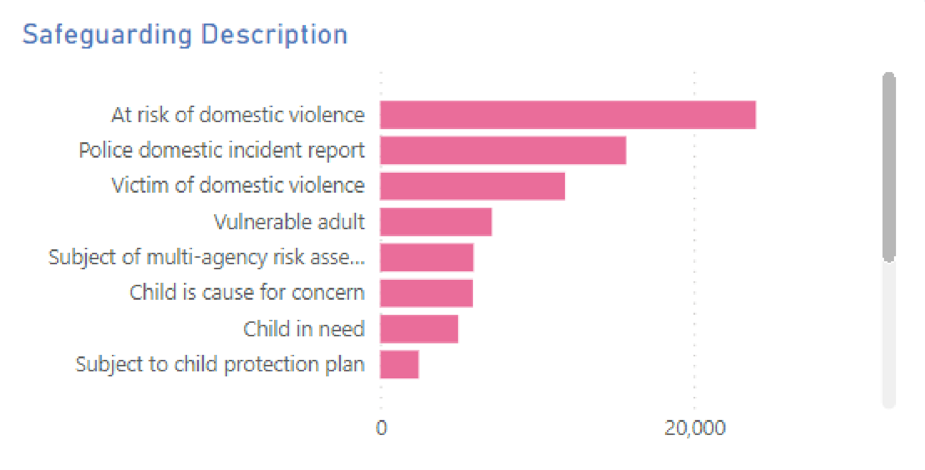
Reset all filters

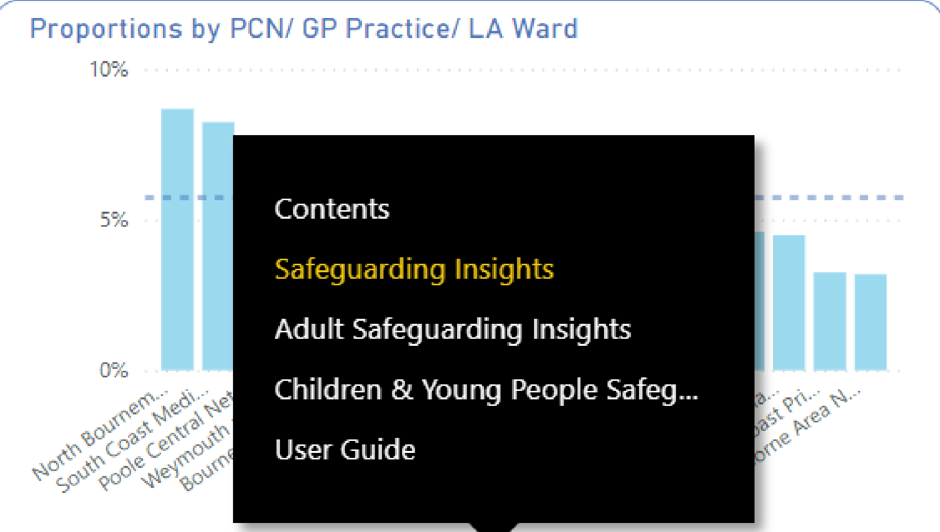


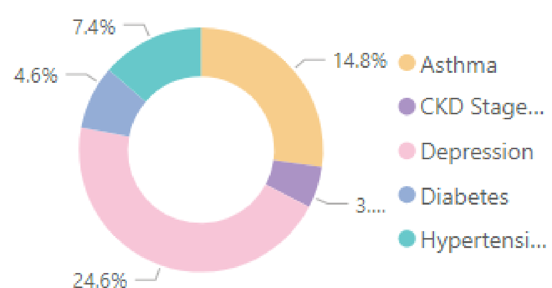


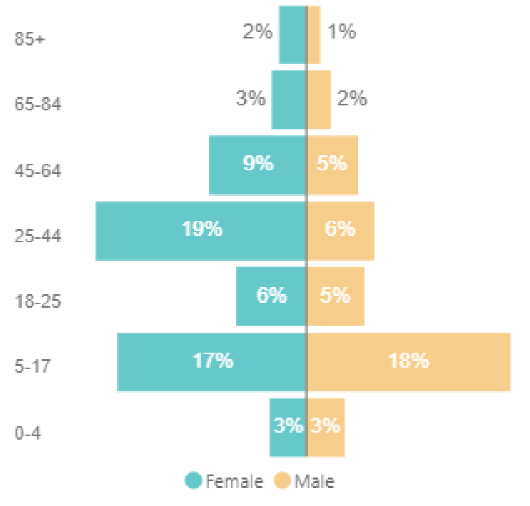
Key characteristics

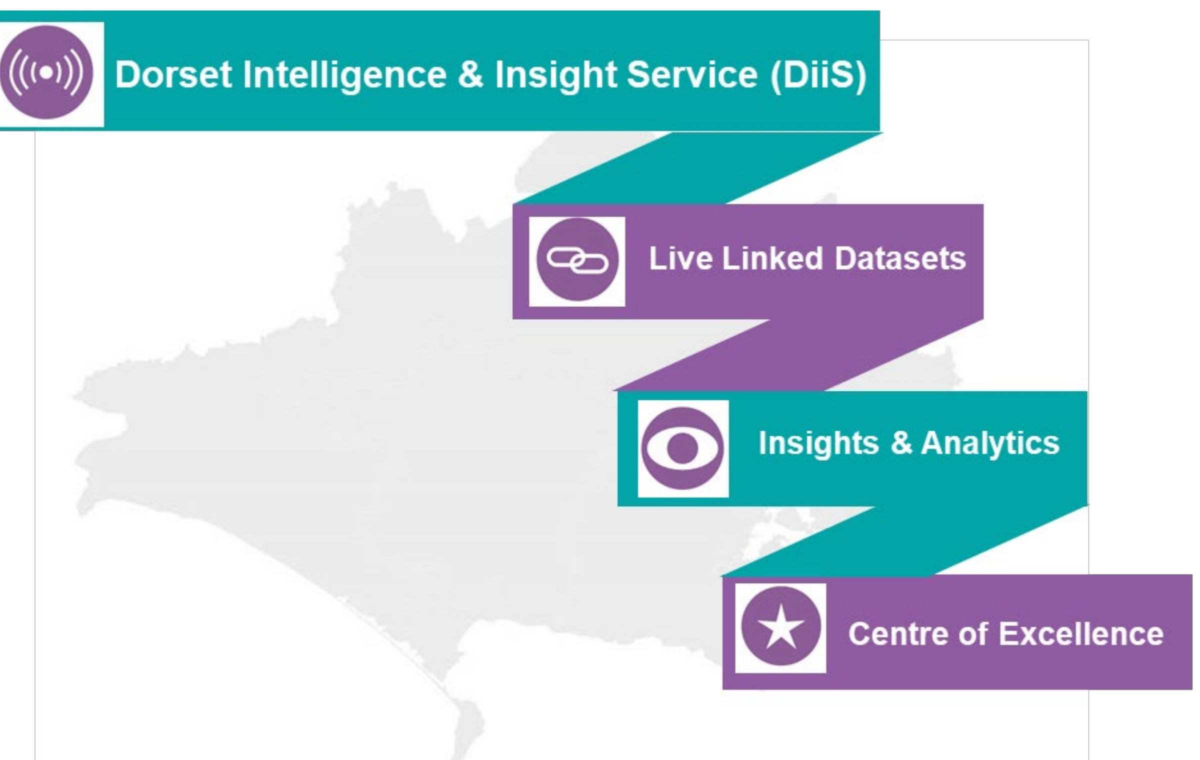
Family neighbourhoods
Renting from social landlord
Families with children
Lower wage service roles
Pockets of social housing
Relatively stable finances
Small bills can be a struggle











Stephen.slough@dorsetccg.nhs.uk
Digital Portfolio Director
Our Dorset ICS

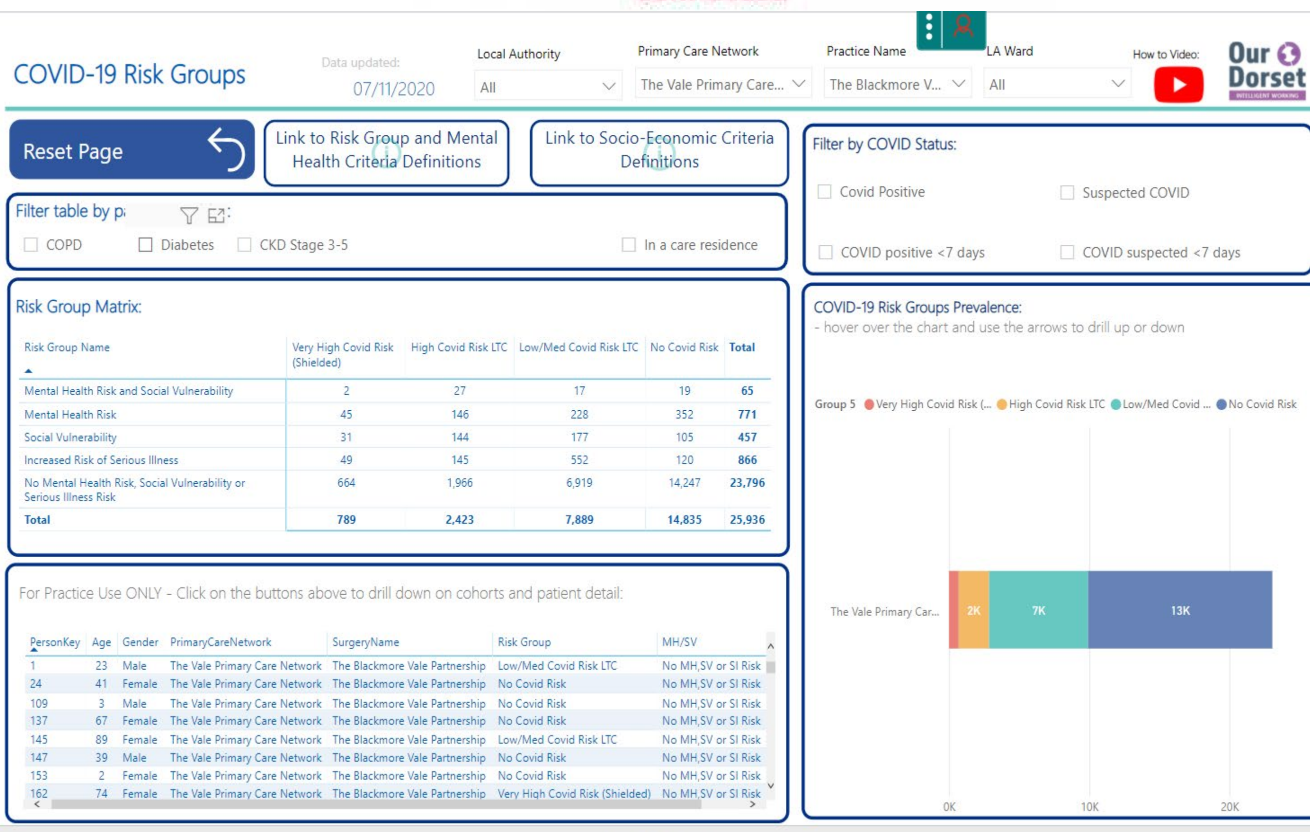
Heather.case@nhs.net
Head of DiiS
Our Dorset ICS

Using Data to Direct our Workforce during Covid

The data from DiiS helped us identify specific patient cohorts segmented by Covid 19 risk factors, mental health and social vulnerability.

We can target different workforces to these groups depending on clinical and social need thus developing a workforce intervention matrix that sits over the segmentation matrix, ensuring a bespoke offer to specific patient cohort need.

This ensures a more structured approach that can be embedded into the ‘front door of primary care’, utilising all members of the SP team inc link worker, health coaches, volunteers and voluntary organisations in a proactive and holistic way.



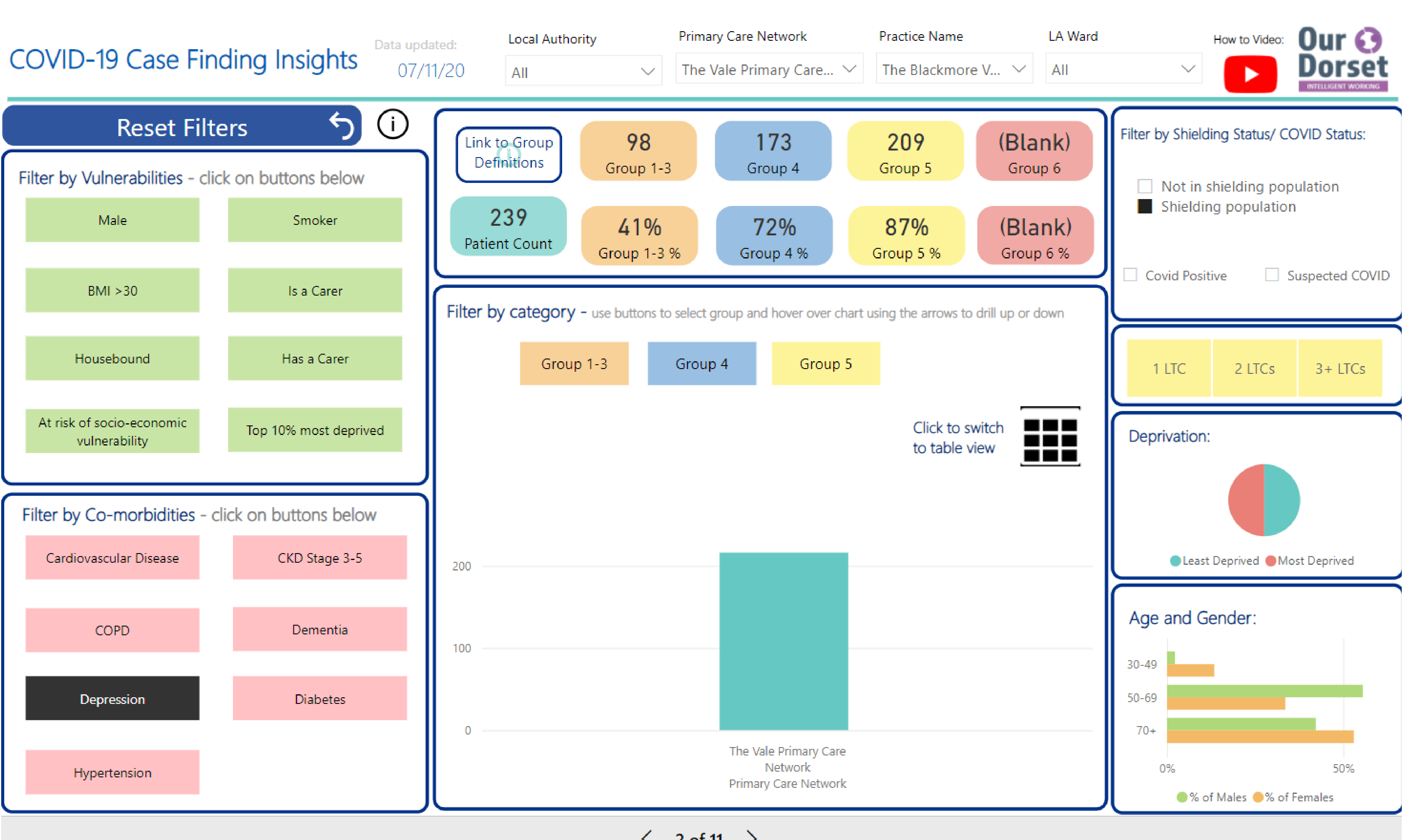
Risk Group Matrix:

Risk Group Name	Very High Covid Risk (Shielded)	High Covid Risk LTC	Low/Med Covid Risk LTC	No Covid Risk	Total
Mental Health Risk and Social Vulnerability	2	27	17	19	65
Mental Health Risk	45	146	228	352	771
Social Vulnerability	31	144	177	105	457
Increased Risk of Serious Illness	49	145	552	120	866
No Mental Health Risk, Social Vulnerability or Serious Illness Risk	664	1,966	6,919	14,247	23,796
Total	789	2,423	7,889	14,835	25,936

For Practice Use ONLY - Click on the buttons above to drill down on cohorts and patient detail:

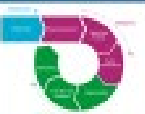
PersonKey	Age	Gender	PrimaryCareNetwork	SurgeryName	Risk Group	MH/SV
1	23	Male	The Vale Primary Care Network	The Blackmore Vale Partnership	Low/Med Covid Risk LTC	No MH,SV or SI Risk
24	41	Female	The Vale Primary Care Network	The Blackmore Vale Partnership	No Covid Risk	No MH,SV or SI Risk
109	3	Male	The Vale Primary Care Network	The Blackmore Vale Partnership	No Covid Risk	No MH,SV or SI Risk
137	67	Female	The Vale Primary Care Network	The Blackmore Vale Partnership	No Covid Risk	No MH,SV or SI Risk
145	89	Female	The Vale Primary Care Network	The Blackmore Vale Partnership	Low/Med Covid Risk LTC	No MH,SV or SI Risk
147	39	Male	The Vale Primary Care Network	The Blackmore Vale Partnership	No Covid Risk	No MH,SV or SI Risk
153	2	Female	The Vale Primary Care Network	The Blackmore Vale Partnership	No Covid Risk	No MH,SV or SI Risk
162	74	Female	The Vale Primary Care Network	The Blackmore Vale Partnership	Very High Covid Risk (Shielded)	No MH,SV or SI Risk

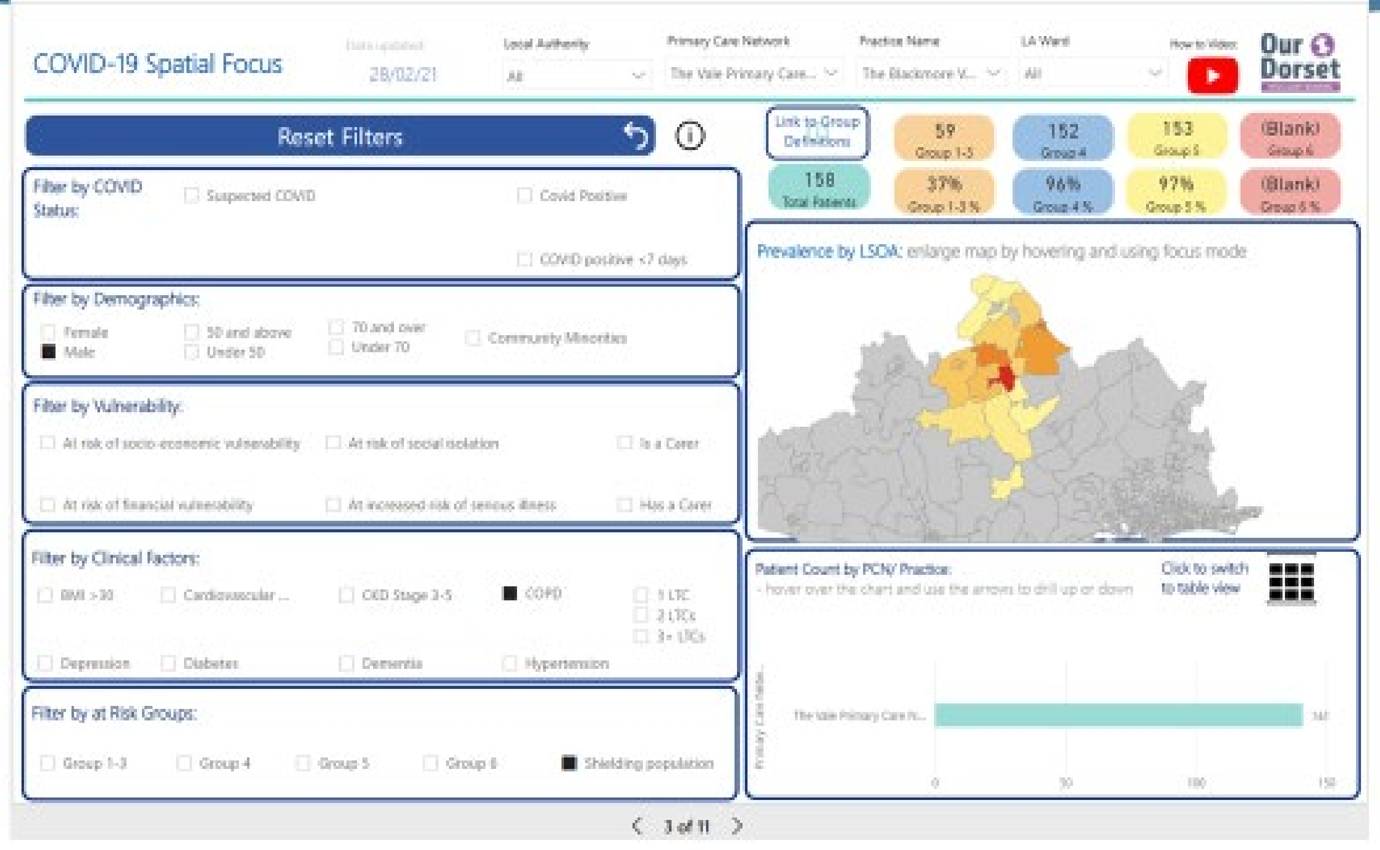
Your Local NHS and Councils Working Together



COVID-19 Case Finding Insights
Data updated:
07/11/20
Local Authority
All
Primary Care Network
The Vale Primary Care...
Practice Name
The Blackmore V...
LA Ward
All
How to Video:
Our Dorset
INTELLIGENT WORKING
Reset Filters
Link to Group Definitions
98
Group 1-3
173
Group 4
209
Group 5
(Blank)
Group 6
239
Patient Count
41%
Group 1-3 %
72%
Group 4 %
87%
Group 5 %
(Blank)
Group 6 %
Filter by Shielding Status/ COVID Status:
Not in shielding population
Shielding population
Covid Positive
Suspected COVID
Filter by Vulnerabilities - click on buttons below
Male
Smoker
BMI >30
Is a Carer
Housebound
Has a Carer
At risk of socio-economic vulnerability
Top 10% most deprived
Filter by category - use buttons to select group and hover over chart using the arrows to drill up or down
Group 1-3
Group 4
Group 5
1 LTC
2 LTCs
3+ LTCs
Click to switch to table view
Deprivation:
Least Deprived
Most Deprived
200
100
0
The Vale Primary Care Network
Primary Care Network
Filter by Co-morbidities - click on buttons below
Cardiovascular Disease
CKD Stage 3-5
COPD
Dementia
Depression
Diabetes
Hypertension
Age and Gender:
30-49
50-69
70+
0%
50%
% of Males
% of Females
2 of 11

Covid 19 Data insights





4x4 Matrix segmentation (COVID-19 risk)

Risk Group Matrix

Risk Group Name	Very High Covid Risk (Shielded) (6A)	High Covid Risk LTC (6B)	Low/Med Covid Risk LTC (6C)	No Covid Risk (6D)	**Total**
Mental Health Risk and Social Vulnerability	115	337	283	202	**937**
Mental Health Risk	973	3089	6537	9836	**20435**
Social Vulnerability	966	3267	3955	1772	**9960**
Increased Risk of Serious Illness	1429	4342	16448	3588	**25807**
No Mental Health Risak, Social Vulnerability or Serious Illness Risk	19959	51469	196042	440256	**707726**
Total	**23425**	**62429**	**223086**	**455349**	**764289**

Emerging need from integrated care system partners to manage new or existing non-Covid risk to avoid medium to long term consequence to population & future system demand

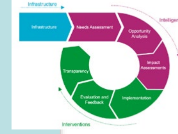
The columns across the top represent the national clinical criteria for COVID-19 risks, grouped into;

- Conditions indicating a need for self-isolation, sub segmented into people with one or multiple risks in this category
- Conditions which indicate the need for shielding

Segments down the side represent people with no mental health or social vulnerability concerns; MH or social vulnerability concern; or both.

The intelligence will allow a wider lens approach to the holistic needs of the population allowing the integrated care system to mitigate against future predicted demand on services such as mental health, long term condition management and socio economic impact on health and wellbeing

INTERVENTION MATRIX



Cross cohort considerations for further tailoring of care offer

- English not first language
- Digital literacy, access
- Key worker?
- Caring responsibilities, who? How?
- Crowded or poor quality housing
- Access to outdoor space

Covid Care Models matrix	No specific Covid risks	Single high risk (local)	Multiple High Risk (local)	Very High Risk/Shielding (National)
All / no specific vulnerabilities	• Whole population messaging on social distancing, health and well-being support and exercise • Maintain social distancing • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Practice nurse check in by phone • Holistic care planning/care plan virtual review/LTC patient APP • Sign posting to tele health options national/local for particular conditions e.g. Help Diabetes national self management web platform.	• Proactive Remote monitoring of blood pressure, blood sugars, weight, drinking etc via patient APP • Virtual Group consultations for linked LTCs (using Somerset LTP patterns)	• Personalised messaging on social distancing and health management for specific groups e.g. cancer, maternity, heart failure, diabetes etc • Home visits where remote [illegible] ot possible [illegible] to address long term [illegible] elephone befriending [illegible], Livewell Dorset etc
Mental health	• National websites, apps and helplines (guided by National MH Covid workstream) • Leaflet drop • Town council helpline • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Pro[illegible] • He[illegible] co[illegible] • Ho[illegible] pa[illegible] wh[illegible] • Health cha[illegible]ion virtual groups • Social prescribing signposting to Dorset MIND for online group support. and access to The Vale First Contact MH practitioner., Steps to Wellbeing.	• Clinician for initial contact proactive case management /MH virtual review • Holistic MDT care planning in partnership with patient (and carer where relevant) • Health Champion virtual support eg. Mindful Café online for dementia.. • Social Prescribing – referral to The Vale MH practitioner., Steps to Wellbeing.	• [illegible] ffer phone call • [illegible] virtual MH review • town council helpline • Teleph[illegible] • Local[illegible] • Socia[illegible] nd The V[illegible]., Steps[illegible] for presc[illegible]
Social vulnerability	• Leaflet drop • Town council helpline • Social prescribing wellness call from Help & Care or local SP practitioner. Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Practice nurse check in • Care coordinator assigned • Holistic care planning in partnership with patient (and carer where relevant) • Practice Nurse for initial contact, then care coordinator with MDT • Social prescribing support signposting to Livewell Dorset/Age Concern	• Clinician for initial contact proactive case management • Holistic MDT care planning in partnership with patient (and carer where relevant) • LA team to support access and training for remote tech from govt scheme. • Health champion peer support . For LTC/Self management.	• Proactive support offer phone call • town council helpline • Telephone befriending • Local authority support • Social Prescribing to self management service offer, signposting to community volunteer support.
Social vulnerability + mental health	• Social prescriber assigned to conduct Wellness Call': • check in, social and practical prescribing including food bank access , town council helpline citizens advice, and broad RVS support • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Practice nurse check in • Health and wellbeing worker assigned • Holistic care planning in partnership with patient (and carer where relevant) • Practice Nurse for initial contact, then health and wellbeing worker with MDT - • Social prescribing support -care co-ordinator appointed, coordinated personal care plan	• Clinician for initial contact, [illegible] management • Holistic MDT care planning i[illegible] patient (and carer where re[illegible] • LA team to support access [illegible] remote tech from govt sche[illegible] • Health champion virtual sup[illegible]	• Proactive support offer phone call • [illegible] council helpline • [illegible]hone befriending • [illegible]l authority support • [illegible]l prescribing - personalised care [illegible] agreed and implemented, offer [illegible]l peer support online or telephone., [illegible]o volunteer support.
Increased risk of serious illness with COVID-19 Diagnosed/suspected Male/age/obesity/dementia etc	• Raise awareness via social media etc regarding risk factors for illness • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• HCA proactive approach • Monitoring via patient APP and pulse oximetry • Social prescribing offer such as LWD smoking cessation support., weight management support for obesity	• Clinician lead proactive case management and monitoring • Monitoring via patient APP and pulse oximetry using virtual ward approach • Social prescribing offer such as LWD smoking cessation support., weight management support for obesity	• Monitoring via patient APP pulse oximetry virtual ward approach • Daily contact with clinician virtually • Social prescribing offer - LWD smoking cessation support., weight management support for obesity reduction , offer of LWD behaviour change coaches ..

Social prescriber resource targeted to where most needed

Making use of community based assets

Cross provider approach to health and social care support offer

Digital technology working alongside more traditional delivery

Digital solutions have been around for years but now is a real opportunity to work smarter using PHM data

TACKLING HEALTH INEQUALITY OUR AIM PHM IS OUR ENABLER

UnVaccinated Focus

Click icon to open filter pane

Data updated to: 23 February 2021

NOTE: Page filters have been applied, check the filters pane or click here to reset all

Our Dorset

UnVaccinated	Eligible
20.9% 71	339
Eligible Non Opt out patients	Non Opt out patients

Risk Groups
- Socio-economic Vulnerability
- Social Isolation
- Financial Vulnerability
- Unhealthy Behaviours

Ethnicity
- Community Minority
- Unknown / Not Recorded ...
- White British

Social Filters
- Has a Carer
- Lives in a Care Home
- Housebound

Deprivation
- Top 20% Most Deprived
- Top 20% Least Deprived

Too many patients to Re-Identify, apply further filters

Primary Care Network / Surgery

The Vale 20.94%

0% 20%

Unvaccinated % by Eligible Group

40% 20% 0%

Clinical Risk 33.8%, Age 2-3 25.0%, Age 65+ 16.3%, BMI 40+ 15.4%, Carer 11.8%, Shielding 3.5%

Eligibility Group

Unvaccinated % by Deprivation (1= Most Deprived)

100% 50% 0%

2: 100.0%, 4: 50.0%, 5: 20.6%, 6: 20.0%, 7: 33.3%, 8: 33.3%, 9: 16.3%

Previous 2 Flu Periods (18/19 & 19/20) for Unvaccinated patients

Vaccinated 2019/2020 Only 4.2%
Vaccinated 2018/2019 Only 2.8%
Vaccinated 32.4%
UnVaccinated 60.6%

0% 50%

Unvaccinated % by Age and Gender

Female Male

Age	Female	Male
65+	33.8%	21.1%
50-64	4.2%	5.6%
19-49	18.3%	11.3%
4-11	1.4%	1.4%
2-3	2.8%	0.0%

Unvaccinated % by Ethnicity Group

11.0 (15.49%)
59.0 (83.1%)

Ethnicity Group (...
- White: Englis...
- Unknown / N...
- White: Other ...

Patient List

PersonKey	Age	# LTCs	Prev 2 Flu Periods	Ethnicity
13847	73	3	UnVaccinated	White: Enc
14590	72	2	UnVaccinated	White: Enc
20057	55	0	UnVaccinated	White: Enc
25026	73	1	Vaccinated	UNKNOW
26005	36	1	UnVaccinated	White: Enc
33817	71	2	Vaccinated	White: Enc
34496	24	2	Vaccinated	White: Enc

Microsoft Power BI

4 of 8

A recording of the webinar, slides and resources will be shared on the

Integrated Care Learning Network.

To join the network email

integratedcare-manager@future.nhs.uk.

5 March 2021